Application for Assistance

- Health Coverage
- Child Care
- Food Stamps
- Telephone Assistance
- Nursing Home Care
- Cash Assistance

Available in Spanish. We provide interpreter services at no cost.
Disponible en español.
Proveemos servicios de interprete sin costo a usted.

IDAHO DEPARTMENT OF HEALTH & WELFARE

For application help, contact this local H&W Office:

or

211 Idaho CareLine
dial 2-1-1 or
1-800-926-2588
TDD 208-332-7205

Appointment Date: _____
Appointment Time: _____

Instructions

To apply for benefits, follow these easy steps:

1. Complete the Application
Complete the three pages of the application. Please be accurate. If you are applying for someone else, answer the questions as they relate to that person.

2. Submit the Application
Once you have completed the application, mail it or bring it to the Health and Welfare office nearest you. The date your assistance will start is based on the date the application is received by the Health and Welfare office, so do not delay. If you are applying for Food Stamps only, you can initiate your application with just your name, address and signature.

3. Provide Any Needed Proof
Look at the table below to see what proof is required for the programs you are applying for. Including copies of the requested proof will help speed the processing of your application.

4. An Interview May Be Required
An interview is not required for health coverage or child care. For Food Stamps, cash assistance, and other programs, you will need to meet with a caseworker before a decision about your benefits can be made. Please contact your local office if you can't come in for an interview during our normal office hours.

Do I Have to Be a Citizen?
No. Please do not let fear of the Immigration and Naturalization Service (INS) keep you from seeking needed benefits for your family. Receiving health coverage, Food Stamps, and child care for your eligible children will not prevent you from gaining lawful, permanent residence or U.S. citizenship, or from sponsoring relatives, if you can support them.

Don't Delay
If you are applying for Food Stamps only, to begin the application process immediately, you only need to give us your name, address and signature.

Equal Opportunity
This application will be considered without regard to race, color, gender, age, disability, religion, national origin, or political belief.

Questions?
If you have any questions about applying, contact your local Health and Welfare office or call 1-800-926-2588. This application also is available on the Internet at www2.state.id.us/dhw and www.idahochild.org.

All applicants for Temporary Assistance for Families in Idaho (TAFI) will be asked to participate in a substance abuse assessment.

Needed Proof by Program

In addition to your application, please provide any proof required for program (s) you are applying for.

	HEALTH COVERAGE for families and children	CHILD CARE**	FOOD STAMPS***	CASH ASSISTANCE	HEALTH COVERAGE for elderly and disabled
Proof you have applied for a Social Security Number (if you don't already have one)	✓		✓	✓	✓
Resident Alien Card (if not a U.S. citizen) or other residency documents	✓		✓	✓	✓
Proof of any other health insurance	✓				✓
Proof of income* or any other money coming into your household		✓	✓	✓	✓
Most recent statements for any bank accounts (checking, credit union, savings, etc.)			✓	✓	✓
Value of car/truck or other vehicles such as motorcycles, boats, RVs			✓	✓	✓
Proof of current value of stocks/bonds, certificates of deposit, life insurance, trusts			✓	✓	✓
Proof of identity			✓		
Proof of any child care costs (if applicable)		✓	✓	✓	
Immunization records for any children not yet in school (if applicable)		✓		✓	

* For example, wage stubs from the last 30 days if you are employed, or federal income tax records if you are self-employed.
** Your child care amount may increase if you provide proof of child support paid for children not living with you.
*** Your Food Stamp amount may increase if you also provide proof of these expenses: child care costs; child support paid for children not living with you; housing costs; utility costs; medical expenses (including prescriptions) for people with disabilities or who are over 60.

Case #: _____ ☐Received by Mail

Assigned to: _____ Date Received: _____

Application for Assistance

Your First Name	Middle Initial	Last Name	Former Names, if any

Home Address	City	County	State	Zip Code

Mailing Address (if different)	City	County	State	Zip Code

Daytime Phone Number	If none, when can we reach you? Phone:	E-Mail Address

I would like to receive:

☐Health Coverage (CHIP or Medicaid) ☐Food Stamps ☐Child Care ☐Telephone Assistance
☐Nursing Home/In-Home Care ☐Cash Assistance ☐Other Services _____

What is your preferred language? Spoken _____ Written _____
Do you want an interpreter if you are interviewed? One will be provided at no cost to you. ☐Yes ☐No
Si usted es entrevistado, ¿quiere ayuda de un interprete? (Un interprete se le proveerá sin costo a usted.)

☞ **Skip this section unless you are applying for Food Stamps.**

Are any members of your household migrant or seasonal farm workers? ☐Yes ☐No
Is your income this month less than $150? ☐Yes ☐No
Are your resources (cash, checking, savings) less than $100? ☐Yes ☐No

If you need Food Stamps right away, benefits can begin within seven days.

To make sure you receive all the help you qualify for, answer the following questions by checking yes or no and listing who:

			Who?
Does anyone in your household have a disability?	☐Yes	☐No	_____
Is anyone in your household applying for or receiving Social Security?	☐Yes	☐No	_____
Do any children in your home have a parent not living with them? *	☐Yes	☐No	_____

(If yes, you will be asked to give information about that parent to Child Support Services. You are required to provide this information to receive most benefits unless you fear harm to yourself or your children.* ***However, you are not required to provide this information to apply only for medical coverage for your child.)*

PERSONAL/AUTHORIZED REPRESENTATIVE: You may authorize someone else to apply for benefits for you and to use your Food Stamp benefits to buy food for you. If you want to name authorize someone, enter his/her name, phone and address below:

Name: _____ Phone Number: _____

Address: _____

NOTE: If your authorized representative gives us incorrect information that causes us to give you benefits you are not entitled to receive, you will have to repay the extra benefits to us.

Source Code

Please list each person who lives in your home. Complete the information on this side of the line for each one. Include unborn children and due date.

Answer the questions on this side only for people requesting benefits. Any Social Security or immigration information on this application is private and will be used only for deciding eligibility.

NAME (First, Middle, Last)	**RELATION** (spouse, child, stepchild)	**DATE OF BIRTH**	**SEX**	**PREGNANT?** (✔ if yes)	**OTHER HEALTH INSURANCE?** (✔ if yes)	**APPLYING FOR?** (✔ all that apply)	**PLEASE COMPLETE THE APPROPRIATE INFORMATION**
	Self		☐M ☐F			☐Health Coverage ☐Food Stamps ☐Other	Social Security #_____ U.S. Citizen: ☐Yes ☐No Alien ID# _____
			☐M ☐F			☐Health Coverage ☐Food Stamps ☐Other	Social Security #_____ U.S. Citizen: ☐Yes ☐No Alien ID# _____
			☐M ☐F			☐Health Coverage ☐Food Stamps ☐Other	Social Security #_____ U.S. Citizen: ☐Yes ☐No Alien ID# _____
			☐M ☐F			☐Health Coverage ☐Food Stamps ☐Other	Social Security #_____ U.S. Citizen: ☐Yes ☐No Alien ID# _____
			☐M ☐F			☐Health Coverage ☐Food Stamps ☐Other	Social Security #_____ U.S. Citizen: ☐Yes ☐No Alien ID# _____
			☐M ☐F			☐Health Coverage ☐Food Stamps ☐Other	Social Security #_____ U.S. Citizen: ☐Yes ☐No Alien ID# _____
			☐M ☐F			☐Health Coverage ☐Food Stamps ☐Other	Social Security #_____ U.S. Citizen: ☐Yes ☐No Alien ID# _____

Please list all money received and/or expected by all household members for this month. If no one in your household receives money, check this box. ☐

TYPES OF MONEY RECEIVED (Wages, Social Security, Child Support, Unemployment, etc.)	**AMOUNT** (Before Taxes or Deductions)	**HOW OFTEN PAID** (Weekly, Monthly, etc.)	**WHO RECEIVED MONEY** (Including Children)

Ethnicity and Race Information

Completion of this section of the Application for Assistance (AFA) is voluntary. Your selection of race and ethnicity will not affect your eligibility for benefits or your benefit amounts. This information is being collected to assure that program benefits are distributed without regard to race, color, or national origin. For the purposes of this section, "Hispanic or Latino" is considered an ethnicity, not a race. **Please answer both ethnicity and race questions for each person.**

Name (First, Middle, Last)	Ethnicity (✓option that best describes each person)	Race (✓one or more options that best describe each person)	Ethnicity and Race Definitions
	☐Hispanic or Latino ☐Not Hispanic or Latino	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White	**Ethnicity Definition** **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. **Race Categories Definitions** **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam **Black or African American** A person having origins in any of the black racial groups of Africa. **Native Hawaiian or Pacific Islander** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. **White** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
	☐Hispanic or Latino ☐Not Hispanic or Latino	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White	
	☐Hispanic or Latino ☐Not Hispanic or Latino	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White	
	☐Hispanic or Latino ☐Not Hispanic or Latino	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White	
	☐Hispanic or Latino ☐Not Hispanic or Latino	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White	
	☐Hispanic or Latino ☐Not Hispanic or Latino	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White	

Please tell us the following information:

1. Does anyone applying for health coverage need help paying medical bills from the last three months? ☐Yes ☐No
   If yes, who? _____. List all income or money received by your family in the last three months.

Last Month	Two Months Ago	Three Months Ago

2. As of today, how much does your household/family (including children) have in:

Cash	Checking	Savings	Other Accounts/Trusts

3. List the year, make, model, and value of each car, truck or motorcycle your household owns. List others on back.

Year/Make/Model/Value/Amount You Owe	Year/Make/Model/Value/Amount You Owe

4. What is the **total value** of other assets such as land, trailers, boats, snowmobiles, other recreational vehicles? (**Do not include the home where you live.**) $ _____

5. List monthly amount paid for dependents or **child care** to someone not living in the home. $ _____

6. List monthly **child support** amount paid to someone not living in the home. $ _____

☞ **Skip questions 7-9 unless you are applying for Food Stamps. List total monthly amounts of any of the following expenses that any member of your household pays or owes. Your Food Stamp amount may increase if you provide proof of these expenses.**

7. **Housing costs** (mortgage/rent, homeowner's insurance, taxes, irrigation, space rent, etc.) $ _____

8. **Utility costs** (do not include past due amounts) $ _____

9. **Medical expenses** (include Medicare and/or health insurance premiums, doctor, dental, prescription, eye glasses, hospital costs, etc.) $ _____

I understand that . . .

- **Knowingly providing false information or withholding information may result in criminal, civil or administrative action (including denial of benefits or required repayment of benefits).**
- **My signature (or the signature of my representative) authorizes State and federal officials to get and use computerized and other information about me to determine if I am eligible for benefits.**
- **I may request a fair hearing if I disagree with decisions made regarding this application, and I have 30 days (90 days for Food Stamps) to do so.**
- **I must turn over any medical reimbursement payments I receive while I am enrolled in State health coverage to the Department of Health and Welfare.**
- **By applying for benefits — other than medical benefits for your child — a child support case must be opened, when applicable.**
- **My signature below certifies that the citizenship/immigration status marked on page 2 is correct for each person applying.**

I, _____, swear that the information given on this form is true and correct.

_____

Signature of Applicant/Authorized Representative **Date**